DPHHS-SLTC-136
(Rev. 1/06)

STATE OF MONTANA
Department of Public Health and Human Services

HOME AND COMMUNITY BASED SERVICES
INTAKE SHEET

Consumer Name: _____ _____
(Last Name) (First Name)

Consumer Medicaid ID #: _____ **Case Management Team No.:** _____

Admit Date: _____ **Readmit Date:** _____

Pay Status: _____ **Medicaid** _____ **Medically Needy**

RESIDENTIAL STATUS PRIOR TO HCBS: (Circle One)

1.	**Institution**	**(1)**	**Nursing Facility**
		(2)	**State Institution**
2.	**Private Residence**	**(1)**	**Lives Alone**
		(2)	**Lives with Parents or Adult Children**
		(3)	**Lives with Spouse**
		(4)	**Shared Living with Relatives**
		(5)	**Shared Living with Non-relatives**
3.	**Group Residence**	**(1)**	**Adult Residential**
		(2)	**Group Home**
		(3)	**Retirement Home**
4.	**Acute Care Hospital**	**(1)**	**From Nursing Facility**
		(2)	**From Private Residence**
		(3)	**From Group Residence**

CARE CATEGORY: (Check One)

3. _____ **Hospital (CC3)**

4. _____ **Nursing Facility (CC1 & CC2)**

5. _____ **Big Sky Bonanza Independence Plus (CC4)**

SERVICES AUTHORIZED: (Check all that apply)

_____ Adult Day Care
_____ Adult Residential
_____ Behavioral Programming
_____ Case Management
_____ Chemical Dependency Counseling
_____ Cognitive Rehabilitation
_____ Community Residential Rehab
_____ Comprehensive Day Treatment
_____ Consumer/Family Intensive Support
_____ Day Habilitation
_____ Habilitation Aide
_____ Home Modification
_____ Homemaker
_____ Homemaker Chore
_____ Nutrition (meals)
_____ Nutritional Counseling
_____ Occupational Therapy
_____ Personal Assistance Services
_____ Personal Emergency Response
_____ Physical Therapy
_____ Prevocational Services
_____ Private Duty Nursing
_____ Psychosocial Consultation
_____ Registered Nurse Supervision
_____ Residential Habilitation
_____ Respiratory Therapy
_____ Respite
_____ Special Child Care
_____ Specialized Medical Equipment
_____ Specialized Medical Supplies
_____ Specially Trained Attendants
_____ Speech Therapy
_____ Supported Employment
_____ Supported Living
_____ Transportation
_____ Vehicle Modification

_____ _____
Signature **Date**